BILL GRAVES. GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

Docking State Office Bldg.
Room 651 South

Health Care Policy / Medical Policy
Robert Day, Director

Phone: (785) 296-3981
Fax: (785) 296-4813

June 20, 2002

Maurice Gagnon
Project Officer
Centers for Medicare & Medicaid
Mail Stop S2-01-16
7500 Security Blvd
Baltimore, MD 21244-1850

RE: Kansas State Children's Health Plan (HealthWave) under Title XXI of the Social Security Act.

Dear Mr. Gagnon:

Attached for your review and approval is the new template for the State Children's Health Insurance Plan to be effective August 21,2001. The services in the template will bring our Title XXI program into compliance with the new federal guidelines in the final rule that was effective on August 21, 2001.

Two versions of the State Plan are attached. One version shows the changes to be made by redlining language that is updated or that has been amended. The other version is the clean version which will be added to the State Plan manual and is the version that we ask that you stamp with the approval date. We have also included the Crosswalk of the Provisions in the Regulation and the SCHIP Template for your review of the plan.

If you or your staff have any questions regarding this proposed template please contact Rita Haverkamp at *(785)* 296-5107.

Sincerely,

Janet Schalansky
Secretary

JS/RH/rh

Attachments

cc: Bobbie Graff-Hendrixson
SRS File Copy

OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at **42** CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Kansas (Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

Janet Schalansky
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances **of** the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Robert M Day PhD. Position/Title: Medicaid Director
Name: Bobbie Graff-Hendrixson Position/Title: Senior Mariager, Managed Care
Name: Marcia Boswell-Carney Position/Title: Fiscal Manager

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70):**

1.1.1. ☒ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103);** OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX); OR**

1.1.3. ☐ A combination of both of the above.

1.2. ☐ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3. ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title 11 of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR Part 80, Part 84, and Part 91, and 28 CFR Part 35. **(42CFR 457.130)**

1.4. ☐ Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65):**

Effective date: August 21, 2001

Implementation date: August 21, 2001

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in **42** CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

From 1997 to today, certain studies arid reports have been promulgated regarding the uninsured in Kansas. In summary, those are:

September 1997 - The Kansas Health Foundation and the Kansas Departnicnt of Health aiid Environment funded a statewide survey **and** review of secondary data on insurance coverage. That survey found that 9.4% of the nonelderly population in Kansas was uninsured, aiid that 31% of the uniiisured were children under age 18 (approximately 64,200 children, based on the 1994 Census figures) who wcrc without insurance at the time of the survey. Another 29.9% of those uninsured at some point during the prior year (approximately 25,700) were in this age group. This results in a range of uninsurance for this age group of 64,200 at a point in time to 89,000 at any time over the past Year. Adding children aged 18 to this review would, by interpolation, increase the range of uninsured to 67,800 to 91,500.

CPS data from 1993, 1094. 1995 - This data is the basis for the SCHIP allocations in FFY 1998. While not statistically significant for Kansas, it showed that there were 60,000 uninsiired children under age 19, plus or minus 12,300, for a range of 47,700 to 72,300 children.

Mach 2001 - Kansas Health Institute Issue Brief 11 - As part of the three-year evaluation of HealthWave 21, the dynamics of the Titlc 21 and Titlc 19 programs between July 1, 1998 and June 30, 2000 wcrc evaluated. One of the findings was a majority (68%) of children entering HealthWave 21 had prior experience with Medicaid, and only 19% to 30% of enrollees were new to public insurance. This implies that while children "aging out" of the stair-step Medicaid eligibility ladder still have access to **no-cost** or low-cost insurance, the program is not reaching as many of the previously uniiisured as was anticipated.

August 2001 - Kansas Health Insurance Study - This study, commissioned by the Kansas Insurance Department and funded by a grant from the Health Resources aiid Services Administration, Department of Health and Human Services, looked at insurance s t a t by~ ~ age, gender, marital status, education, employment status. **arid** region. Questions about the reasons for uninsurance and health status were asked. This study found that 7.8% of children under age 19 were not insured at tlic time of the survey. While this percentage is lower than that found **in** tho August 1997 survey for children under age 18 (9.4% versus 7.8%), it

translates into approximately 55,600 children. based on the 2000 population figures for Kansas from the Census Bureau.

Other notable findings wcrc that children were enrolled in Medicaid/HealthWave 21 at tlirec times tlie rate of the general public, and that the main reason for uninsurance was the cost.

These studies in the aggregate imply that between 1997 and 2001, the reduction in the number of uninsured children under age 19 is somewhere between 12.200 and 35,900, with some enrolled in Medicaid and some enrolled in HealthWave 21.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs **(i.e.** Medicaid and state-only child health insurance):

Initially tlie program's outreach focus was on a broad-based mass-marketing effort by the state's outreach and marketing contractor to gain recognition for the program. Beginning July 1,2001, the focus shifted to localized and targeted outreach by the SRS area offices and the RWJ/KCSL outreach partners.

Outreach and enrollment activities for Medicaid programs are administered through the Department of Social and Rehabilitation Services. Education regarding the Medicaid program is provided to advocacy groups, schools, health care professionals, social service agencies, and other community organizations who may have contact with children requiring health insurance coverage in an effort to enlist the help of these organizations in identifying children without health insurance coverage and assisting the families in making application for Medicaid. There are also staff located in local field offices and in Central Office who conduct public awareness and education activities for the Medicaid program. In addition, local field staff have out stationing duties at disproportionate shared hospitals and the Federally Qualified Health Centers in the State including Hunter Health Clinic (FQHC, **MS,** & RHC) and United Methodist Health Clinic (FQHC) in Wichita. This provides additional opportunities for outreach and education as well as the initial processing of Medicaid applications.

Outreach activities for Maternal and Child Health and Title **V** programs are conducted through the Kansas Department of Health and Environment. Through an inter-agency agreement, SRS staff refer consumers potentially eligible for these programs to the appropriate agency for eligibility determination. KDHE staff also refer potential Medicaid eligibles to SRS.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Prior steps taken with the CARING program were completed in a very short time frame resulting in most of these children enrolled in SCHIP or Medicaid. The state has enacted legislation to promote business partnerships and initial meetings for design and implementation are taking place in 2002.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5.)***
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The State's SCHIP program is marketed as a health insurance program. The marketing program includes coordination of efforts with state and local governmental entities and other child serving agencies, including the:

- Kansas Department of Education
- local Unified School Districts
- Local Health Departments
- Kansas Insurance Department
- community based organizations, including Indian Health Clinics, providing services to American Indian children, and

Other local community programs that deal with families of potentially-eligible children including such traditional providers as:

- Head Start
- school-based clinics
- Women Infant and Children (WIC) programs
- Maternal Child Health (MCH) programs
- pre-schools
- child-care organizations
- parent-teacher associations
- religious organizations
- grass-root organizations
- other community-based organizations that deal with children.

The specific target audience of consumers are:

- Low-income, Kansas families, up to **200% of** the federal poverty level
- Families with uninsured children, **0-18** years of age, who are potentially eligible for the SCHIP or Medicaid Program
- Families with children with special health care needs
- Families without knowledge of, or access to, available health care coverage for their children
- Potentially eligible youth, **16-18** years of age who may be living independently
- Schools, Local Health Departments, other governmental and private service agencies that interface with low income families
- Health care providers including hospitals, physicians, dentists, mental health providers and other providers of health care as directed by the SRS staff.

A single application form for both Title XIX and SCHIP is used and'made widely available at numerous access points. In addition a toll free number **(1-800-792-4884)** is established where interested persons can call for information and to request **an** application form. Applications are self-addressed for return to a central processing unit. The family still has the option of submitting applications to the local **SRS** office. Once received, the application is reviewed for Tile XIX eligibility first, and then for Title XXI eligibility if Title XIX eligibility is not established. No reapplication is necessary by the consumer for SCHIP determination.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

By state statute, service delivery for the SCHIP program is provided through capitated managed care arrangements. Limited benefits are carved out and paid fee-for-service. The benefits carved out are dental services over $1,500 in any contract year, major organ transplants, antihemophiliac drugs, and vaccine biologicals. All other heath services are obtained through direct contracts with MCOs or MCEs chosen for participation as a result of a competitive Request for Proposal (RFP) process. The program is statewide, with coverage and access requirements contained in the contracts and monitored by the state. Children, through the physical health contractor, are enrolled with a primary care provider who coordinates their health care. including referrals to specialists, where appropriate.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Utilization control mechanisms are in place for the SCHIP program to ensure that children use only health care that is appropriate, medically necessary, and approved by the State or the participating health plan.

Before being approved for participation in the SCHIP Program, health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

More information can be found on utilization control in Section 7 – Quality and Appropriateness of Care.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☐ Geographic area served by the Plan: The plan is available statewide.

4.1.2. ☒ Age: Children from birth to age 19 are served.

4.1.3. ☐ Income: Income up to 200% FPL for the SCHIP program. Current Medicaid definitions of family income and those income deductions, disregards, and budgeting methods specified in the State's Title XIX State Plan is applicable to the SCHIP population

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): No resource test is applied.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Children must be residents of Kansas. The citizenship and immigration status requirements applicable to Title XIX shall also be applicable to SCHIP.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage: Children are ineligible for SCHIP if currently covered by other health insurance or eligible for Medicaid coverage.

4.1.8. ☐ Duration of eligibility: Annual eligibility determination. Twelve months of continuous eligibility is also applicable to both Title XIX and SCHIP even if family income increases above the income threshold.

4.1.9. ☐ **Other standards (identify and describe):**

- To be eligible for SCHIP coverage, families above 150% of the poverty level must agree to pay a monthly premium which does not exceed the limitations of section 2103(e).

- Children are ineligible for SCHIP coverage if they are eligible for health coverage under the Kansas Group Health Insurance Program, if they are an inmate in a public correctional institution, or if they are a patient in an institution for mental diseases.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

A simplified application/enrollment form is used to access both Medicaid and SCHIP coverage. The form is available through a number of access points including schools, churches, medical providers, etc. The forni is mailed in along?with supporting documentation such as wage information to a central clearinghouse. The clearinghouse is responsible for initial processing and eligibility determination for both Medicaid and SCHIP and involves privately contracted staff. The Medicaid state agency administers the portion of the clearinghouse responsible for Medicaid determination and case maintenance. Contracted staff is responsible for all SCHIP processing and determinations as well as ongoing?case management.

The Income Eligibility Verification System (IEVS) is used to confirm income information on an ongoing basis and tlic Systeniatic Alien Verification for Entitlements (SAVE)program os an appropriate alternative is used to verify immigration status.

Eligibility is continuous for 12 months and re-established annually. The family must meet all eligibility criteria and have paid any applicable premiums from the prior year to be re-enrolled for a new 12 month period.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☐ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

Most current Medicaid financial and non-financial requirements as specified in the Title XIX State Plan is applicable to both the Medicaid and SCHIP populations. The central clearinghouse described in section 4.3 determines initial eligibility for either Medicaid or SCHIP by reviewing income and other information submitted by families. Families are provided coverage under either Medicaid or SCHIP dependent upon total income available.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Through the use of a combined simplified application/enrollment form and the central clearinghouse, eligibility is determined for either Medicaid or SCHIP coverage based on income and age level.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

All applications are first reviewed for potential Medicaid eligibility, those found ineligible for Medicaid are immediately screened for SCHIP eligibility. This process occurs at the same location, with the same workers, and no referral is required.

4.4.4. The insurance provided under the state child health plan does, not substitute for coverage under group health plans. Check the appropriate **box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The application/enrollment form is used to ascertain current health insurance coverage as well as access to stale employee coverage. Children found to have current health coverage are denied eligibility for SCHIP coverage.

In addition, access to state employee coverage results in denial of benefits under the SCHIP program.

Premiums are charged to families above 150% of FPL *in* the SCHIP program.

The central Clearinghouse application processing contractor monitors for substitution for coverage under group health plans through their application decisions software.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3.0 Coverage provided to children in families above **250%** FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4 If the state provides coverage under a premium assistance program, describe:

N/A

The minimum period without coverage under a **group** health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

The State has undertaken the following actions:

- Including ethnic information on the application for tracking Iridian numbers.
- Including in the outreach media campaign and other outreach activities, the names of the community based organizations that serve Indian children, to assure that families are aware of the program and assist in the enrollment process.
- Using the three Indian Health Clinics as access points to provide enrollment materials and assistance to potentially eligible children.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Kansas uses methods to reach families when parents are receptive to the consideration of obtaining health insurance for their children. School-based events, such as Kindergarten Round-ups, school enrollments, and program flyers sent home during the winter flu season are methods used to communicate the availability of public health insurance. School nurses assist outreach efforts by informing families of this insurance option.

Scheduled times at other public venues for families to complete an application are effective. Application assistance can take place in licalth departments during WIC pickup days, or at the state fair in September.

The business community is an effective partner in reaching parents. Many employers open their workforce and places of business to presentations and application assistance.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section **7.**

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))**
(If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage.''

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population (EPSDT)

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by "existing comprehensive state-based coverage"

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☐ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☐ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. a Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☒ Inpatient mental health services, other than services described in **6.2.18,** but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in **6.2.19,** but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☐ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section **6.4.2.** of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: ***Previously*** 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)** N/A

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to **a** state in excess of the **10%** limitation on use of funds for payments for: **1)** other child health assistance for targeted low-income children; **2)** expenditures for health services initiatives under the plan for improving the health **of** children (including targeted low-income children and other low-income children); **3)** expenditures for outreach activities as provided in section **2102(c)(1)** under the plan; and **4)** other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis.** **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section **330** of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 6
Attachment A

OVERVIEW OF THE BENEFITS SCHEDULE

The Kansas State Children's Health Plan is known as HealthWave.

Copayments and Deductibles

No copayments or deductibles may be charged to HealthWave members for any of the three service categories, Physical Health Services, Behavioral Health and Substance Abuse Services, and Dental Services listed below. HealthWave members may be liable for the cost of services not covered under this contract, or for the cost of services obtained without following approved prior authorization procedures.

Medical Necessity: Medical necessity means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

- Authority. The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
- Purpose. The health intervention has the purpose of treating a medical condition.
- Scope. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
- Evidence. The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph **(3).** For existing interventions, effectiveness shall be determined as provided in paragraph **(4).**
- Value. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. ***An*** intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. ***An*** intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to **an** individual case, the characteristics of the individual patient shall be determinative.

The following definitions shall apply to these terms only as they are used in this subsection:

- "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
- "Health outcomes" means treatment results that affect health status as measured by the length or quality of **a** person's life.
- "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
- "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.
- "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.
- "Treat" means to prevent, diagnose, detect, or palliate a medical condition.
- "Treating physician" means a physician who has personally evaluated the patient.

Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph **(4).**

The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

PHYSICAL HEALTH SERVICES

Physician Services

- Physician services shall include: Diagnostic and treatment services by participating physicians and other participating health professionals; including office visits; periodic health assessments including school and camp physicals; hospital care; consultation; manipulation; surgical and non-surgical office procedures and injectable medications administered by the physician or medical staff under direction of the physician

Outpatient Services

Outpatient services shall consist of all services requested or directed by the Contractor, or primary care physicians to be provided on an outpatient basis, including diagnostic and/or treatment services; health evaluations, well-child care and routine immunizations according to Centers for Disease Control (CDC) guidelines; drugs administered in an outpatient setting, prescription medications, biologicals, and fluids; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, the administration of blood and blood products, recovery room services, ambulatory surgical centers, and hospital outpatient surgical centers.

Inpatient Hospital Services

Inpatient Hospital Services are provided upon prior approval of the Contractor, for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or on an outpatient basis. Hospital Services shall include semi-private room and board; care and services in an

intensive care unit; administered drugs, prescribed medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy, radiation therapy; and such other services customarily provided in acute care hospitals.

Inpatient Services at Other Participating Health Care Facilities

A Participant shall be entitled to inpatient services at Other Participating Health Care Facilities for a minimum of sixty (60) days per Contract Year, when medically appropriate as determined by the Contractor. Services shall include semi-private room and board; care and services in an intensive care unit; administered drugs, medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy, radiation therapy; and such other services customarily provided in acute care hospitals.

Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy, including physical, speech and occupational therapy, are provided on an inpatient or outpatient basis. Services provided on an outpatient basis are at a minimum of one hundred eighty (180) consecutive days per condition if significant improvement can be expected within sixty (60) days of the first treatment, as determined by the Contractor. Contractor may conduct periodic evaluations as required to assure continued medical necessity. Such coverage is available only for rehabilitation following injuries, surgery or acute medical conditions.

Home Health Services

Home health services are provided for a participant who requires skilled care and is home bound due to a disabling condition, is unable to receive medical care on an ambulatory outpatient basis, and does not require confinement in a hospital or other participating health care facility. Home health services shall be provided by an accredited home health agency which is a participating provider. Home health services include visits by professional nurses and other participating health professionals (including home health aides), consumable medical supplies and durable medical equipment administered or used by such persons in the course of services rendered during such

visits, medical social services for the terminally ill, and drugs administered in the home setting which are prescribed by a participating provider and which are covered under the plan. Physical, occupational and speech therapy provided in the Home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy".

Diagnostic Laboratory and Diagnostic and Therapeutic Radiology Services

Diagnostic laboratory and diagnostic and therapeutic radiology services shall include electrocardiograms; electroencephalograms; radiation therapy; Computer Aided Tomography (CAT) scans, Magnetic Resonance Imaging (MRI) procedures, and other diagnostic and therapeutic procedures.

Maternity Care

Maternity care shall include medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Family Planning Service Access and Confidentiality

Family Planning Services are a covered benefit. Examples of family planning and reproductive health services are: contraception management, insertion and removal of Norplant, insertion and removal of IUD, Depo Provera Injections, Pap test, pelvic exams, sexually transmitted disease testing, family planning counseling/education or various methods of birth control.

Services for Infertility

Infertility services are covered as determined by the Contractor. These include diagnostic services to establish cause or reason for infertility. Artificial Insemination is covered subject to a maximum of three billable attempts per year of eligibility subject to prior authorization by the Contractor. There is no coverage for donor fees, collection and/or storage of sperm or any other related services.

Vision Services

Vision Services are covered, These services include one complete eye exam, one pair of glasses including frames and lenses as needed, and repairs as needed, for members. Eye exams for post-cataract surgery patients up to one year following the surgery and eyeglasses for post-cataract

surgery members are covered when provided within one year following surgery. Contact lenses and replacements are covered when ordered by a qualified Contractor provider and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses.

Eye prosthesis includes postsurgical lenses customarily used during convalescence from eye surgery, are covered when ordered by a qualified Contractor provider.

Ambulance Service

A Participant is entitled to ambulance service, provided such ambulance service is Medically Necessary and authorized by the Contractor, or the use of such ambulance service is determined to have been an Emergency Service, as defined in the "Emergency Services" provision below.

Prescribed Drugs

A Participant is entitled to prescribed drugs as defined below. Bidders must propose their Prior Authorization (PA) List. Future PA additions must be prior approved by SRS.

Plan Design:

Formulary: Open

Quantity/Days Supply: 34-day supply or less (one standard quantity)

Refills: available after 75% of the original supply has been consumed

Prior Authorization may include, but is not limited to: growth hormone, amphetamines/amphetamine mixtures, Accutane, Retin-A

Maximum allowable quantity list: -- must be included in the Vendor's Proposal.

EXCLUSIONS:

- Drugs for cosmetic purposes
- Drugs available without a prescription, except insulin, acetaminophen, ibuprofen, multivitamins, oral electrolyte solutions (such as Pedialyte), cough and cold preparations.
- Appetite suppressants, anorexiants or diet aids
- Experimental or investigational drugs
- Drugs not registered with the FDA or that do not have FDA approved indications
- Drugs furnished by local, state or federal government and any drug to the extent payment of benefits are provided or available from local, state or federal government whether or not that payment **or** benefit is received, except as otherwise provided by law.
- Replacement prescription drugs resulting from loss or theft.

Emergency Services

1. Definition of Emergency Services. Services which would be considered emergent by a prudent layperson must be covered under the Contract as required by the Federal Balanced Budget Act of 1997.

2. Emergency Services Within the Service Area. Emergency Services within the Service Area must be obtained from the Primary Care Physician or other Participating Providers. Participating Providers must be available on call twenty-four (24) hours a day, seven **(7)** days a week, to assist Participants needing Emergency Services. Emergency Services obtained other than as set forth above are covered only if the Contractor, on review, determines that the Participant had no control over where or by whom the Emergency Services were rendered.

3. Emergency Services Outside the Service Area. Participants are covered for Emergency or urgent care services outside the Service Area. Participants must contact the Contractor covering the required emergency service immediately for direction and authorization; however, this requirement shall not cause denial of an otherwise valid claim if the Participant could not reasonably comply, provided that notification is given to the Contractor as soon as reasonably possible. The Contractor, at its option, may arrange to transfer a Participant to a Participating Provider for continued care when medically prudent to do so.

4. Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, are covered unless authorized in advance by the Primary Care Physician or the Contractor.

Internal Prosthetic/Medical Appliances

Coverage for Internal Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for defective body parts. Repair or maintenance of a covered appliance is covered. Prosthetic devices are limited to the first surgically implanted device and the first ocular or prosthesis required as a result of accidental injury. The plan covers artificial limbs only to the extent of the first such artificial limb required. Special braces required to maintain the function of a disabled limb or required to support a functionally impaired body part. Penile implants only when required as a result of diabetes or other medical conditions. There is a maximum of one implant per lifetime which is a covered benefit unless the prosthetic device or appliance is no longer suitable due to continued growth and/or development, providing the original prosthetic device or appliance was originally provided to a child.

Breast Reconstruction and Breast Prostheses

Incidental to a mastectomy, the Participant shall be provided surgical services for breast reconstruction and up to two (2) external post-operative breast prostheses.

Durable Medical Equipment

Durable Medical Equipment, including medical supplies and equipment, which include those necessary for the administration of insulin; and asthma supplies such as, but not limited to, spacers, nebulizers, peak flow meters are covered when deemed necessary and ordered by the primary care physician.

Organ Transplant Services

A Participant is entitled to receive benefits for human organ and tissue transplant services **,** at limited facilities throughout the United States, as designated by the Contractor, subject to the conditions and limitations below.

1. **Definition of Transplant Services.** Transplant services are the recipient's medical, surgical and hospital services, inpatient immunosuppressive medications, and organ procurement required to perform the following human to human organ or tissue transplants: kidney, cornea. Other tissue or organ transplants; bone marrow, heart, heart/lung, liver or pancreas, shall be reimbursed on a fee-for-
service basis (inpatient hospital service costs only) with prior approval of SRS. The Contractor shall cover all non-inpatient costs associated with these transplantation services.

2. Preauthorization. Coverage for transplant services must be authorized by the Contractor based on the medical criteria and methodology employed by a transplant facility designated by the Contractor.

Nutritional Evaluation

Initial nutritional evaluation and counseling from a Participating Provider is provided when diet is part of the medical management of a documented disease, including morbid obesity.

Hospice Services

Hospice Care Services when provided, due to Terminal Illness, under a Hospice Care Program is covered. Hospice Care Services shall include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; bereavement counseling once every six weeks, and Home Health Services.

Hospice Care Services do not include the following:

- services or supplies not listed in the Hospice Care Program;
- services for curative or life prolonging procedures;
- services for which any other benefits are payable under the Contract;
- services or supplies that are primarily to aid the Participant in daily living in excess of 10 days per month;
- services for respite care;
- nutritional supplements, non-prescription drugs or substances, medical supplies vitamins or minerals.

Oral Surgery Benefits

Benefits for Oral Surgical Procedures of the jaw or gums are covered for;

1. Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. Removal of exostoses (bony growths) of the jaw and hard palate;
3. Treatment of fractures and dislocations of the jaw and facial bones;
4. Intra-oral X-rays in connection with covered oral surgery if treatment begins within 30 days.
5. General anesthetic for covered oral surgery.

Anti-hemophiliac factors: Providers are directly reimbursed on a Fee-For-Service basis with prior approval of **SRS.**

Vaccine Purchases: MCOs are encouraged to coordinate with Kansas Immunization Program Providers in MCO covered regions to facilitate the Immunization Program. MCOs should encourage their network providers not currently participating in the Vaccines for Children program to apply to become Kansas Immunization Program Providers by completing the "Vaccines For Children" (VFC) Program 1998 Provider Enrollment Form.

The following vaccines are available in the Vaccines For Children Program. Contractors are notified of any changes to this list of available vaccines.

Vaccines included in the CDC Recommended Childhood Immunization Schedule

Diphtheria, Tetanus, acellular Pertussis (DtaP)
Diphtheria, Tetanus, Pertussis (DTP)
Diphtheria, Tetanus toxoid combined (DT)
Tetanus, Diphtheria toxoid combined (Td)
Haemophilus influenza type B (HIB)
Haemophilus influenza type B, Hepatitis B comb. (HIB/HepB)
Polio Virus, live, oral (OPV)
Polio Virus, inactivated (IPV)(
Measles, Mumps, Rubella (MMR)
Hepatitis B, pediatric, birth - 10 years (Hep B ped)
Hepatitis B, high risk, 11 - 18 years (Hep B high risk)
Hepatitis B, adult (Hep B, adult)
Varicella Virus Vaccine (Var)

The following vaccines if indicated:
Hepatitis A (Hep A)
Influenza Virus (Flu)
Pneumococcal (Pneumo)

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

Inpatient and Outpatient Behavioral Health Services

Coverage of medically necessary inpatient and outpatient mental health/behavioral health services for "biologically based" mental illnesses is a requirement under this Contract. For the purpose of this Contract "biologically based" means the following:

a. Schizophrenia, schizo affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
b. major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
c. obsessive compulsive disorder;
d. panic disorder
e. pervasive developmental disorder, including autism;
f. other childhood mental illnesses, including attention deficit disorder and attention deficit hyperactive disorder; or
g. borderline personality disorder.

Substance Abuse Services

Inpatient:

Coverage is provided for up to sixty (60) days per plan year, when medically necessary, for rehabilitation when required for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization by the Contractor or its designee. Inpatient services are covered only if provided by a facility designated by the Contractor.

The benefits may be exchangeable with partial hospitalization sessions, if medically necessary and appropriate, of not less than three (3) hours and not more then twelve (12) hours in any twenty-four (24) hour period, based upon the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient day of the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange shall be two (2) partial hospitalization sessions equal to one day **of** inpatient care. If the charge for one partial hospitalization session does not exceed fifty (50) percent of the allowable charges for one inpatient day for the average semi-private rate at the Participating Hospital where the session is conducted, the benefit exchange is one partial hospitalization session equal to one day of inpatient care.

Outpatient: Up to twenty-five (25) visits per plan year. Group therapy sessions count as ½ of an individual session.

Detoxification Services: Coverage is provided for detoxification and related medical ancillary services when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. The Contractor decides, based upon medical necessity, whether such services are provided in **an** inpatient or outpatient setting.

Section *6*
Attachment A

DENTAL SERVICES

Coverage for preventative and necessary dental benefits is a requirement under this Contract. The Contractor providing dental management services shall cover the following dental care services:

Diagnostic: Includes procedures necessary to assist the dentist in evaluating existing conditions and the dental care required.

Oral examinations twice per plan year not to exceed one every four months

Diagnostic x-rays; bitewings twice per plan year not to exceed one every four months for dependents under age 18 and once every twelve months for adults age 18 and over.

Full mouth x-rays once every five years.

Preventive: Provides for the following:

Prophylaxis/cleaning (including periodontal maintenance) twice per plan year not to exceed one every four months

Topical fluoride twice per plan year not to exceed one every four months

Space maintainers only if under age 9 for premature loss of primary molars

Sealants one per four years for children under age 17 for permanent molars with no decay or restorations.

Ancillary: Provides for visits to the dentist for the emergency relief of pain

Oral-surgery: Provides for extractions and other oral surgery including pre- and post-operative care.

Regular Restorative Dentistry: Provides amalgam, synthetic porcelain and composite white resin restorations on front teeth.

Endodontics: Includes necessary procedures for root canal treatments and root canal fillings.

Periodontics: Includes procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.

Special Restorative Dentistry: When teeth cannot be restored with a filling material listed under Regular Restorative Dentistry, provides for gold restorations and individual crowns. Buildup and pins covered if tooth had a previous root canal treatment.

TMJ: Limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction.

Prosthodontics: Includes bridges, partial and complete denture, including repairs and adjustments.

Annual Dental Cost Limits: Costs above **$1,500** in any contract year is paid on a Fee-For-Service basis with prior approval of SRS.

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section **8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards

Tools to assure quality will include:

- ■ Written provider credential standards.
- ■ Written descriptions of quality standards
- ■ Annual audits of plan compliance
- ■ Process to survey consumers and providers

7.1.2. ☐ Performance measurement

Tools to measure performance will include:

- ■ Well-child screening rates
- ■ Immunization rates
- ■ Responses to satisfaction surveys
- ■ Prenatal care compliance
- ■ Primary care visit rates

7.1.3. ☐ Information strategies

Tools to measure information strategies will include:

- ■ Review of enrollment materials
- ■ Survey results
- ■ Grievance results

7.1.4. ☒ Quality improvement strategies

Tools to monitor quality improvement strategies will include:

- Corrective action plans
- Compliance audits
- Review of utilization rates
- Review and approval of quality studies

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

The state uses quality standards, performance measurements, information strategies, and quality improvement strategies to achieve the goals established with the implementation of managed care as a delivery system for SCHIP. The following definition of quality of care guides quality management.

> "Quality care achieves the best possible health outcomes and functional health status by delivering the most appropriate level of care in a safe environment, with the least possible risk. Quality care is accessible and efficient, provided in the appropriate setting, according to professionally accepted standards, in a coordinated and continuous, rather than episodic, manner."

Goals underlying the implementation of this quality care are:

To improve the quality of services provided to the SCHIP population.
A central component of the quality management program is the ongoing evaluation of the provision of care and the measurement of key outcomes related to specific conditions or diagnoses important to the SCHIP population.

To improve consumer access to health care.
The quality management program includes specific access standards which address access to providers, appointments, maximum distance and other structural measures of access to care. Evaluation of outcomes focus on access to primary care services.

Ensure and protect consumer rights and dignity.
Consumers are provided a written copy of specific program rights and responsibilities upon enrollment. A consumer survey is sent one time per year to assess consumer satisfaction.

EXTERNAL MONITORING

External Quality Review Organization (EQRO)

The EQRO does perform on a periodic basis, a review of the quality of services furnished by each managed care contractor. External quality review includes three types of activities: focused studies of patterns of care; individual case review in specific situations; and follow-up activities on previous pattern of care study findings and individual case review findings. This provides SRS and federal government with an independent assessment of the quality of health care delivered to SCHIP beneficiaries enrolled in contracting HMOs. The EQRO works to resolve identified problems in health care and contributes to improving the care of all SCHIP beneficiaries. The EQRO works closely with the State and contracting HMOs to insure workable implementation of external review.

INTERNAL MONITORING

Contract Compliance Review

Each of the contracts between SRS and participating health, dental and vision plans contain specific performance objectives. SRS monitors contracting HMOs, on a periodic basis, to determine compliance with these performance objectives. Areas to be monitored include, but are not limited to:

- The HMO's complaint/grievance policies and procedures
- The policies and procedures used by the HMO to safeguard confidential information
- The contents and scope of HMO contract with practitioners
- Coordination and continuity of care
- The HMO's credentialing process
- The HMO's denial policies
- The scope of the HMO's member service effort, including health education and prevention programs
- Enrollment/disenrollment policies and procedures
- Medical records policies and procedures, accessibility and availability
- Provider network and access to covered services
- The HMO's organizational structure and administration to monitor and evaluate the care delivered to enrollees
- The HMO's process to survey members and providers

Grievance Review

A grievance is defined as an expression of dissatisfaction about any matter including a denial of or limited authorization of requested service(s).

A grievance requires formal written documentation. A thorough investigation is made and appropriate resolution presented to the consumer. All calls and letters from members are received in the customer service unit. Every inquiry (calls or letters) are logged. Once the inquiry is logged, it is evaluated to determine if the inquiry should be handled by professional medical staff.

Professional medical staff receives grievances regarding utilization, quality of care, and access. Each inquiry is researched thoroughly and responded to. Clinical education is given to members by this staff.

At any time a consumer may request a fair hearing from the state in conjunction with a grievance.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Methods to ensure access include, but are not limited to the following:

- Monitoring of numbers of various providers in each county.
- Study of twenty four hour seven day a week accessibility on a random basis.
- Studies of waiting times - offices, hospital ER, and clinics.
- Monitoring of enrollment, and disenrollment reports.
- Monitoring of grievances.
- Study of distance and travel time between providers and consumers
- Consumer satisfaction surveys.
- Study of emergent and non-emergent patterns of ER usage.
- Study of appointment time (office, urgent, emergent) scheduling.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to **an** adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Contracts with the MCOs require the following:

- Access Standards which is inclusive of specialty networks;
- Assignment of beneficiaries; and
- Referral Standards

These issues are monitored through the EQRO by their annual audit of the MCO.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs **of** the patient, within **14** days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The contracts with the MCOs require that decisions regarding all covered services be made no longer than 48 hours after the request.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section **9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ **YES**

8.1.2. ☐ NO, **skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: $10 per month per family where family income is between 151% and 175% of FPL
$15 per month per family where family income is between 176% and 200% of FPL

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: None

8.2.4. Other: None

8.3. Describe how the public is notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)(1)(B)) (42CFR 457.505(b))**

Information regarding premiums is provided with the application and upon eligibility determination and redetermination if the family is in premium paying status.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state ensures that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Premium limits were established to insure that the aggregate cost-sharing for a family did not exceed 5% of the family's annual income. Families have the option of paying monthly, quarterly, or on any other basis convenient to the family. The only requirement is that the full amount of the premium requirement be paid before renewal.

Premiums charged for coverage of children above 150% of the poverty level do not exceed 1% of the total family income. Premiums may be reduced or eliminated based on reported decreases in income during the year.

8.6 Describe the procedures the state uses to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children are excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

An ethnicity designator is collected at the time of application. This is a self-declaration field on the application. If the indicator for a family is marked American Indian or Alaskan Native and they are eligible for Title XXI, no premium is charged.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

An enrollee family has a full year to meet their premium obligation. Notices are sent monthly outlining the amounts due, or paid. At 45 days before the end of the eligibility period, a final notice is sent informing the enrollee that if the premium is not paid in full coverage ends. An enrollee must pay all delinquent premiums, or provide information that they are no longer in a premium paying status, before eligibility is redetermined.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

☐ In the instance mentioned above, that the state facilitates enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

☐ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☐ No Federal funds are used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☐ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) is used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** ***(Previously* 8.4.5)**

8.8.3. ☒ No funds under this title are used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title includes coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title are used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

1. Reduce the number of uninsured non-Medicaid eligible children under 19 years of age and below 200% FPL in the State of Kansas.
2. Assure that the enrolled children with significant health needs have access to appropriate carc.
3. Assure that tlie enrolled children receive high quality health care services.
4. Increase the percentage of enrolled children with regular preventive care.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Strategic Objective #1

Performance Goal: Enrollment in HealthWave 21 continues to increase by 4,000 lo 5,000 children per federal fiscal year, until the enrollment reaches a total of 40,000. At that time tlie uninsurance rate is reevaluated.

Performancc Measure: The enrollnient data and current population survcy.

Strategic Obiective #2

Performance Goal: Children that are identified as Title V children receive specialty care.

Performance Measure: Interagency data on Title V enrollment and specialty assignments.

Strategic Obiective #3

Performance Goal: Annually at least 80% of SCHIP enrollees report overall satisfaction with their health care plan.

Performance Measure: The Consumer Assessment of Health Plan Study (CAHPS) survey results.

Strategic Objective #4

Performance Goal: At least 80% of enrolled children receive one or more Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.

Performance Measure: Administrative data.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: **(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))**

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☐ The reduction in the percentage of uninsured children.

9.3.3. ☐ The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The State of Kansas currently follows, and plans to continue to follow, the template for the **annual** report provided by NASHP.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. ☒ The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☐ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The conception of the SCHIP program in Kansas occurred through multiple stakeholder meetings during 1997 and 1998. These meetings included members of the Kansas Legislature, Kansas Insurance Department, Kansas Medical Society, The Kansas Department of Health and Environment, local pediatricians **and** pharmacists, physical health providers, health care professional associations, SRS employees and advocacy groups. Their input was used in the design of Senate Bill 424, which authorized the SCHIP plan for the State of Kansas.

Physical health **plan** contractor has a group of beneficiaries that provides input regarding the service delivery and when applicable forwards those comments to the State for incorporation.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR $457.125. **(Section 2107(c)) (42CFR 457.120(c))**

The Secretary of the Department of Social and Rehabilitation Services holds a semi-annual meeting with the Tribal Government in the State of Kansas to discuss issues and receive input. **A** process for written notice in compliance with federal regulation is in place.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d)

No changes have been made since the regulation regarding prior public notice.

9. 3 Provide a one year projected budget. A suggested financial form for the budget is attached The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

Submitted with the original SCHIP State Plan.

☐ Planned use of funds, including --
- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

☐ Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☐ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue to Section 12.

11.1. ☐ The state assures that services are provided in an effective **and** efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** ***The items below were moved from section 9.8. (Previously items 9.8.6.-9.8.9)***

11.2.1. ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☐ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1. Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR $457.1120.

The state contracts with a private entity to manage, determine and redetermine elgibility and to collect premium fees.

Health Services Matters

12.2. Please describe the review process for **health services matters** that complies with 42 CFR $457.1120.

The state contracts with an External Quality Review Organization (EQRO) to perform an annual audit of the Titlc 21 Service Delivery Program.

Premium Assistance Programs

12.3. If providing coverage through a group health plan that does not meet the requirements of 42 CFR $457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

N/A